TEXT OF PROPOSED CHANGES
TO THE REGULATIONS OF THE
COMMISSIONER OF CORPORATIONS
UNDER THE
DATED: June 7, 2000

1. Amend Section 1300.68 to read:

1300.68. Grievance System.

Every health care service plan shall establish a ~~A plan~~ grievance system ~~established~~ pursuant to the requirement of Section 1368 of the Act~~. shall include at least the following features:~~

(a) The grievance system shall be established, pursuant to written procedures, for the receipt, handling and ~~disposition~~ resolution of ~~complaints~~ grievances within 30 calendar days of receipt by the plan, or the entity contracted by the plan to administer its grievance system. The following definitions shall apply with respect to the rules relating to grievance systems:

(1) "Grievance" is defined to mean any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative to a plan or to any entity with delegated authority to resolve grievances on behalf of the plan. Where the plan is unable to distinguish between grievances and inquiries, they shall be considered grievances.

(2) "Complaint" is the same as a "grievance".

(3) "Complainant" means the person who filed the grievance whether on his or her own behalf or on the behalf of the enrollee.

(4) "Resolved" means finally decided with no further opportunity for the enrollee to appeal the decision to the plan. If the plan has multiple internal levels of grievance resolution or appeal, all levels must be concluded so that the complainant has a final resolution of the grievance within 30 days of the plan's receipt of the grievance.

(b) The plan's grievance system shall include at least the following features.

(1) An officer of the plan shall be designated as having primary responsibility for the maintenance of such procedures and for the review of their operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the plan's administration whether or not the plan administers its own grievance system or delegates its authority to resolve grievances to another entity.

~~(b)~~(2) At least one telephone number for the filing of ~~complaints~~ grievances shall be located within each service area including facilities of providers which are used by the plan. The locations for filing ~~complaints~~ grievances and telephone numbers and related procedures regarding grievances shall be communicated in writing to enrollees and subscribers.

~~(c)~~(3) As to each ~~complaint~~ grievance received in person or by telephone at a grievance location, a written record shall be made, including the date, identification of the individual recording the grievance, and disposition. A written record of tabulated grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to Section 1300.69, and by an officer of the plan or his designee, and the review procedure shall be documented, including documentation of the procedure or mechanism used in consideration of tabulating grievances periodically in relation to policy and procedure review.

~~(d)~~(4) At each grievance location, assistance shall be provided in the filing of grievances. A "patient advocate" or ombudsperson may be used.

~~(e)~~(5) Complaint forms and a copy of the grievance procedure shall be readily available at each facility of the plan and the plan shall provide them to subscribers and enrollees promptly upon ~~receipt of a~~ request.

~~(f)~~(6) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a ~~complaint~~ grievance.

~~(g)~~(7) A grievance system shall provide (1) for the acknowledgement of the receipt of a ~~complaint~~ grievance and notice to the complainant of who may be contacted with respect to the ~~complaint~~ grievance within ~~20~~ five (5) days, and (2) for notice and a written statement to the complainant of the disposition or pending status of the ~~complaint~~ grievance within 30 days of the plan's receipt of the ~~complaint~~ grievance. ~~Where the plan is unable to distinguish between complaints and inquiries, they shall be considered complaints.~~

~~(h)~~(8) A grievance system shall provide for a prompt review of ~~complaints~~ grievances by the management or supervisory staff responsible for the services or operations which are the subject of the ~~complaint~~ grievance.

(9) Copies of grievances and responses that the plan is required to maintain for five years, shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied to reach its decision.

(10) The grievance system shall include procedures for the expedited review of grievances for cases involving imminent and serious threat to the health of the enrollee, and shall include the elements set forth in Rule 1300.68.01.

(c) Department review of grievances.

An enrollee may submit a grievance to the Department for review, after completing the plan's grievance process or after having participated in the plan's grievance system for 30 days; however, this requirement shall be waived if the Department determines that an earlier review is necessary. Upon receipt of such grievance, the Department shall notify the plan in writing, and the plan shall submit within five (5) calendar days after receipt of the notification, the following information:

(1) The plan's response to the issues raised by the enrollee's request for assistance filed with the Department.

(2) A copy of the plan's response to the enrollee's grievance filed with the plan.

(3) A complete and legible copy of any and all medical records related to the grievance.

(4) A copy of the cover page of the applicable evidence of coverage and other relevant pages of the evidence of coverage with the specific sections pertaining to the enrollee's grievance underlined.

(5) Any other relevant information that the plan used to reach its decision.

(6) Any other information that the plan believes is relevant to the resolution of the grievance.

(7) If the plan did not use medical records or did not rely upon any information other than the evidence of coverage to make its decision, the plan shall so state in its response to the Department.

The Department may request additional information or medical records from the plan. Should additional information be requested, the plan shall submit this information within five (5) calendar days of receipt of the Department's request.

Any delay caused by the plan's failure to submit the requested information may result in the Department ruling in the enrollee's favor on any issue that the Department cannot decide without the information in question.

~~(i)~~(d)(1) The quarterly report required by subdivision (c) of Section 1368 of the Act shall include ~~complaints~~ grievances filed by enrollees that are pending and unresolved for 30 days or more within the plan's grievance system. When a plan's grievance system provides one or more opportunities for appeal, an enrollee's ~~complaint~~ grievance shall be included in the plan's quarterly report until the enrollee has exhausted all opportunities for appeal or the time for appeal under the grievance system has expired. The quarterly report shall not include

~~complaints~~ grievances filed and/or processed outside the plan's grievance system in other ~~complaint~~ grievance resolution procedures, such as arbitration, voluntary mediation, the Center for Dispute Resolution, an independent review organization, the California Department of Social Services or ~~and~~ the Department ~~of Corporations~~.

(2) A plan that has no ~~complaints~~ grievances within the plan's grievance system that are pending and unresolved for 30 days or more shall file the quarterly report required by subdivision (c) of Section 1368 of the Act notifying the Department of that fact.

(3) The quarterly report shall be prepared for the quarter ending on March 31st, June 30th, September 30th and December 31st of each calendar year, and shall include ~~complaints~~ grievances pending and unresolved for 30 days or more during the quarter. The quarterly report shall not contain personal or confidential information with respect to any enrollee.

(4) The quarterly report shall specify the licensee's name, quarter and date of the report, categories reported, type of grievance system based on levels of appeal, and a breakdown of the total number of pending and unresolved ~~complaints~~ grievances for each category and for each level of the plan's grievance system. The breakdown shall include the number of ~~complaints~~ grievances for each corresponding reason specified in the report. If ~~complaints~~ grievances are pending and unresolved for reasons other than reasons specified in the quarterly report, those other reasons shall be specified in the report together with the corresponding number of ~~complaints~~ grievances for each reason. If a grievance system provides two or more levels of appeal, each level shall be separately listed in the report and shall include the same information required by the report for First-Level Appeals.

(5) The quarterly report shall be signed by a person authorized to do so by the plan, verified, and filed along with two copies of the quarterly report, in the Department's Sacramento Office to the attention of the Health Plan Division Filing Clerk no later than 30 days from the close of the quarter. The quarterly report need not be filed as an amendment to the plan application.

(6) The quarterly report shall be filed in the format specified below:

STATE OF CALIFORNIA
DEPARTMENT OF CORPORATIONS

QUARTERLY REPORT OF
PENDING AND UNRESOLVED GRIEVANCES
PURSUANT TO HEALTH AND SAFETY CODE
SECTION 1368(c)

1. Name of Licensed Health Plan (as appearing on license):
_____

2. Report for Quarter Ending: _____

3. Categories of ~~Complaints~~ Grievances Included in this Report: (Include total plan enrollment for each category.)

Category		Enrollment
( )	Commercial	_____
( )	Medicare (Risk)	_____
( )	Medicare (Supplement)	_____
( )	Medi-Cal	_____

4. Type of Grievance System Based on Levels of Appeal Allowed by Plan:
( ) Initial ~~Complaint~~ Grievance Only (No Appeal Allowed)
( ) One-Level Appeal (One Appeal Allowed)
( ) Two-Level Appeal (Two Appeals Allowed)
( ) Multi-Level Appeal (Three or More Appeals Allowed)

5. Breakdown of number of pending and unresolved ~~complaints~~ grievances for each category and each level in the grievance system, as follows:

Category: _____

INITIAL ~~COMPLAINTS~~ GRIEVANCES

Number of ~~Complaints~~ Grievances	Reasons
_____	.....Pending additional information from enrollee.
_____	.....Pending additional information from provider.
_____	.....Pending plan's review and determination.
	Other Reason(s) (Specify):
_____	.....a. _____
_____	.....b. _____

_____.....c. _____
(Continue, if necessary)

_____.....TOTAL INITIAL ~~COMPLAINTS~~ GRIEVANCES

FIRST-LEVEL APPEALS

Number of
~~Complaints~~ Grievances Reasons

_____.....Pending receipt of any appeal filed by enrollee.
_____.....Pending additional information from enrollee.
_____.....Pending additional information from provider.
_____.....Pending plan's review and determination.

Other Reason(s) (Specify):
_____.....a. _____
_____.....b. _____
_____.....c. _____
(Continue, if necessary)

_____ TOTAL FIRST-LEVEL APPEALS

[NOTE: If the Grievance System provides two or more levels of appeal, each level shall be separately listed, and shall include the same information required by the report for First-Level Appeals.]

_____ TOTAL NUMBER OF ~~COMPLAINTS~~ GRIEVANCES FOR THIS CATEGORY

[NOTE: List breakdown for next category of ~~complaints~~ grievances marked in Item 3. as set forth in Item 5.]

VERIFICATION

I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true.

By: _____
(Signature of Individual Authorized to Sign on Behalf of the Plan.)

Name: _____
(Typed or Printed)

Title: _____

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference cited: Section 1368, Health and Safety Code.

2. Adopt Section 1300.68.01 to read:

1300.68.01. Expedited Review of Grievances.

(a) Every plan shall include within its grievance system, procedures for the expedited review of grievances for cases involving the imminent and serious threat to the health of the enrollee ("urgent and emergency request"). At a minimum, procedures for the expedited review of grievances shall include the following:

(1) The plan shall immediately notify the complainant of his or her right to notify the Department of the grievance,

(2) The plan shall provide the complainant and the Department with a written statement on the disposition or pending status of the urgent and emergency request, within three (3) days of receipt.

(3) The enrollee's medical condition shall be considered when determining the plan's response time.

(b) The plan shall designate a primary contact person and at least two back-up contact persons who have the authority to authorize and/or intervene in health care services and treatment decisions, and have the authority to make decisions, including financial decisions for the expenditure of funds to ensure that no harm comes to the enrollee, on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan.

When contacted by the Department during normal business hours, the primary contact person (or the back-up contact persons) shall respond to the Department's urgent and emergency requests within 15 minutes. If the Department contacts the primary contact person (or the back up contact persons) after normal business hours, on weekends or holidays, the

primary contact person (or back-up contact persons) shall respond to the Department's urgent and emergency request within one hour.

(c) Plans shall provide the Department with the following information:

(1) A current organization chart showing lines of authority and communications, by the names and titles of persons who are responsible for responding to the Department on urgent and emergency requests.

(2) The names, titles, telephone numbers, pager numbers, answering service or voice mail numbers, and the e-mail addresses of the primary and back-up contact persons who will respond to the Department regarding urgent and emergency requests during normal business hours.

(3) The names, titles, telephone numbers, pager numbers, answering service or voice mail numbers, and the e-mail addresses of the primary and back-up contact persons who will respond to the Department regarding urgent and emergency requests after normal business hours and on weekends.

(4) The upcoming monthly schedule, indicating on a day-by-day basis, the primary and back-up contact persons and their hours of duty. The schedule shall also include the names, titles, email addresses, telephone numbers, pager numbers, answer service and/or voice mail numbers for each primary and back-up contact person. The plan shall provide this monthly schedule to the Department's Consumer Services Unit at least five (5) days before the first day each month.

(5) The plan shall immediately notify the Department upon any change to the contact person, back-up contact persons, any contact numbers or to the monthly schedule.

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1368 and 1368.01, Health and Safety Code.